Nicholas A. Toumpas
Commissioner

Mary P. Castelli
Senior Division Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

THERAPEUTIC CANNABIS PROGRAM

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
email: ginger.dubois@dhhs.state.nh.us

Written Certification for the Therapeutic Use of Cannabis

WRITTEN CERTIFICATION INSTRUCTIONS FOR MEDICAL PROVIDERS

Information about the Therapeutic Cannabis Program, including the enabling law (RSA 126-X), the administrative rules (He-C 400), and all required forms, is available on Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

1. Carefully read the general program information available on the Program's website.
2. Type or print in ink your responses on the Written Certification. All certifications on this form that require signature or initialing must be completed in ink. Photocopies or facsimiles of this form will not be accepted.
3. Failure to complete this Written Certification in its entirety will cause your patient's application to be incomplete.
4. Give the completed Written Certification to your patient to submit to the Program. DO NOT send the form directly to the Program; it must accompany the patient's application.
5. As part of the application review and verification process, the Program will contact your office to verify that you signed and issued the Written Certification. The certifying medical provider will not be required to personally verify this information; confirmation by office personnel will be considered sufficient. Without such confirmation, your patient's application will be considered incomplete.
6. You must meet the definition of "provider" as defined in He-C 401.02(i), namely, "(1) A physician licensed to prescribe drugs to humans under RSA 329 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances; OR (2) An advanced practice registered nurse licensed to prescribe drugs to humans under RSA 326-B:18 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances."
7. You must have a "provider-patient relationship" with the patient you are certifying. This means that you must have at least a 3-month medical relationship between you and the patient, during which you have conducted a full assessment of the patient's medical history and current medical condition, including an in-person physical examination of the patient; a medical history of the patient, including a prescription history; a review of laboratory testing, imaging, and other relevant tests; appropriate consultations; a diagnosis of the patient's current medical condition; and the development of a treatment plan for the patient appropriate for your specialty.
8. The 3-month requirement for the provider-patient relationship shall not apply if you certify that the onset or diagnosis of the patient's qualifying medical condition occurred within the past 3 months, and that you are primarily responsible for the patient's care related to his or her qualifying medical condition.
9. Your patient must have a "qualifying medical condition" as defined in RSA 126-X:1, IX(a). This means that your patient must have BOTH a condition AND an associated symptom or side effect, as follows:

   "Qualifying medical condition" means the presence of:

   (a) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C currently receiving antiviral treatment, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, or one or more injuries that significantly interferes with daily activities as documented by the patient's provider; AND

   (b) A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms.

WRITTEN CERTIFICATION
FOR THE THERAPEUTIC USE OF CANNABIS

Instructions: Complete all sections of this form. Please type or print in ink your responses on this form.

PATIENT INFORMATION

Name	Last	First	Middle
Mailing Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			
Date of Birth	MM/DD/YYYY		

PROVIDER INFORMATION

Name of Physician or APRN	Last		First	Middle
Name of Medical Practice				
Office Mailing Address	Street/P.O. Box		County	
	City		State	Zip Code
Office Phone Number	Work	Extension	Fax	
NH License Number			☐ Physician ☐ Advanced Practice Registered Nurse	
DEA Number				
Medical Specialty				

Please include the following information for the person in the office to be contacted by the Program in order to facilitate the processing and verification of this Written Certification.

Name and Title	
Phone Number	
Email Address	

PROVIDER'S CERTIFICATION OF A PATIENT'S QUALIFYING MEDICAL CONDITION

INSTRUCTIONS: You must certify that your patient has BOTH the condition AND the associated symptom or side effect.
You must complete both sections below.

I certify that I am treating ______________________________ who has the following condition(s):
(Patient Name)

- ☐ Cancer
- ☐ Glaucoma
- ☐ Positive status for human immunodeficiency virus
- ☐ Acquired immune deficiency syndrome
- ☐ Hepatitis C currently receiving antiviral treatment
- ☐ Amyotrophic lateral sclerosis
- ☐ Muscular dystrophy
- ☐ Crohn's disease
- ☐ Multiple sclerosis
- ☐ Chronic pancreatitis
- ☐ Spinal cord injury or disease
- ☐ Traumatic brain injury
- ☐ Epilepsy
- ☐ Lupus
- ☐ Parkinson's disease
- ☐ Alzheimer's disease
- ☐ One or more injuries that significantly interferes with daily activities as documented by the provider.

If this box is checked, you must identify your patient's injury or injuries and describe in sufficient detail how it significantly interferes with your patient's daily activities. Additional sheets may be attached if needed.

I certify that __________________________ has a severely debilitating or terminal medical condition,
(Patient Name)
side effect, or its treatment that has produced the following:

Check all that apply; there must be at least one box checked.

- ☐ Elevated intraocular pressure
- ☐ Cachexia
- ☐ Chemotherapy-induced anorexia
- ☐ Wasting syndrome
- ☐ Agitation of Alzheimer's disease
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects
- ☐ Constant or severe nausea
- ☐ Moderate to severe vomiting
- ☐ Seizures
- ☐ Severe, persistent muscle spasms

______________________________ ______________

Signature of Certifying Provider **Date**

PROVIDER'S CERTIFICATION OF A PROVIDER-PATIENT RELATIONSHIP

INSTRUCTIONS: Certify that you have a provider-patient relationship with your patient.

"Provider-patient relationship" means at least a 3-month medical relationship between a licensed provider and a patient, unless the 3-month requirement does not apply in accordance with He-C 401.06(b)(1)b., during which the provider has conducted a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2). This rule requires the full assessment to include an in-person physical examination of the patient; a medical history of the patient, including a prescription history; a review of laboratory testing, imaging, and other relevant tests; appropriate consultations; a diagnosis of the patient's current medical condition; and the development of a treatment plan for the patient appropriate for your specialty.

Initial one of the following boxes, and provide applicable information.

	I have completed a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2) [as described above] made in the course of a provider-patient relationship of at least 3 months in duration. The dates of the provider-patient relationship are: ____
	I have completed a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2), [as described above] but I do not have a provider-patient relationship of at least 3 months in duration. The onset or diagnosis of my patient's qualifying medical condition occurred within the past 3 months, and I am primarily responsible for the patient's care related to his or her qualifying medical condition. The date of the onset or diagnosis of my patient's qualifying medical condition is: ________________________

Initial the following box.

	I have explained the potential health effects of the therapeutic use of cannabis to my patient. If my patient is a minor, I have explained to my patient's custodial parent or legal guardian with responsibility for health care decisions for the patient both the potential health effects and the potential risks and benefits of the therapeutic use of cannabis.

I certify that I am:

☐ A physician licensed in New Hampshire to prescribe drugs to humans under RSA 329 and who possesses and active registration from the United States Drug Enforcement Administration to prescribe controlled substances; or

☐ An advanced practice registered nurse licensed in New Hampshire to prescribe drugs to humans under RSA 326-B:18 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances.

I possess an active license in good standing with the State of New Hampshire, and the facts as stated in this Written Certification are accurate to the best of my knowledge and belief. I understand that any false statements made on this written certification are punishable as unsworn falsification under RSA 641:3.

____ ______________________

Signature of Certifying Provider **Date**

DURATION OF WRITTEN CERTIFICATION

A patient's Registry Identification Card will be valid for one year from the date of issuance, at which point you must provide a new Written Certification to allow your patient's continued therapeutic use of cannabis. If the Registry Identification Card should be valid for a shorter duration, then indicate for how many months the card shall remain valid.

The Registry Identification Card shall remain valid for:

☐ One year from the date of issuance OR ☐ _________ months from the date of issuance

THIS FORM AS COMPLETED IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE THERAPEUTIC USE OF CANNABIS